ROUND ROCK, TEXAS

PURPOSE. PASSION. PROSPERITY.

2014 BENEFITS GUIDE

Plan Year 2014
At A Glance

- City of Round Rock will have one medical plan, one deductible, and one out of pocket maximum for the Plan Year 2014.
- There are three cost tiers for the medical plan only in 2014: Employee Only, Employee plus Child(ren) and Employee plus Family. The 2013 Employee plus Spouse will be included in the Employee plus Family tier for cost purposes.
- Free generics both for retail prescriptions as well as mail order delivery prescriptions.
- Hearing aids are now covered up to $4,000 annually, subject to the deductible and coinsurance.
- City paid life and accidental death & dismemberment insurance at one times annual salary up to a maximum of $100,000.
- Aexcel is a new inner-network in Aetna's current network and results in maximum savings for the plan member. Copays for specialist are cheaper for those utilizing the Aexcel network. When searching for specialists on the Aetna network look for a blue star beside their names in the listings to designate membership in Aexcel.
- The dental and vision plans will remain the same. Employee/Spouse coverage will be available with these plans.
- Urgent Care Provider copay is now $35
- Physician Office Visit copay is now $25. Specialist Office Visits are $25 for Aexcel network, $45 in regular Aetna network.
- Mental Health Outpatient Office Visit Copay and Alcohol/Drug Abuse Office visit copay is $45
- Emergency Room Visits are subject to deductible with a $200 Copay

This guide highlights the main features of many of the benefit plans sponsored by the City. Full details of these plans are contained in the legal documents governing the plans. IF there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. The City reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time.

Table of Contents

Contact Information

Resource	Phone/Web Address
Aetna - Medical	(888)416-2277 www.aetna.com
Aetna – Pharmacy	(866)612-3852 www.aetna.com
Aetna – Dental	(877)238-6200 www.aetna.com
Aetna – Vision	(888)416-2277 www.aetna.com
Aetna - Flexible Spending Accounts	(800)972-3862 www.aetna.com
Deer Oaks - Employee Assistance Program	(866)EAP-2400 www.deeroaks.com eap@deeroaks.com
Lincoln Financial Group	Abby Randazzo (866)510-4750 ext 127 abby.randazzo@LFG.com
Nationwide – Deferred Compensation Program	(877)677-3678 Miguel Figueroa: 512-423-9217 FIGUERM1@nationwide.com
Texas Legal Protection Plan	(512)327-1372 www.TLPP.com
Texas Municipal Retirement System (TMRS) Supplemental Death Benefit	(800)924-8677 (512)476-7577 www.TMRS.com
City of Round Rock – HR Department	Jay Light – Benefits Manager (512)341-3143 jlight@roundrocktexas.gov Sharon Callis, Benefits Specialist (512)671-2701 scallis@roundrocktexas.gov

Benefits Guide Information

The City of Round Rock employees have access to benefits approved by the City Council each year as part of the budget process. The benefits and services offered by the City may be changed or terminated at any time. These benefits are not a guarantee of your employment with the City. This Guide is designed to help you understand your benefits. Review this material carefully before making your enrollment decisions. Your rights are governed by each plan and not by the information in this Guide. If there is a conflict between the plan document and this Guide, the terms of the plan document govern. For detailed information about the plans, refer to each plan document, contact the vendor or the Employee Benefits Division of the Human Resources Department.

City Benefits Philosophy

The City is concerned for the health and welfare of its employees and is committed to providing cost-effective benefits that assist employees in being physically and mentally healthy. All benefit plans require employees to assume responsibility for the choices they make and to be informed on how to use their benefits effectively.

Administration

The overall administration of the benefits program is re-evaluated and revised periodically to ensure it is simple, efficient, cost effective, and satisfies overall goals.

Communications

In keeping with this philosophy, the City will explore other areas of benefits to the extent they fill a need of a major portion of the workforce and to the extent they be provided cost effectively and efficiently on a group basis. A variety of media is used to communicate the benefits program to employees and their dependents. Methods used include presentations, newsletters, email and the City's website. In addition, benefits staff is available by phone or in person to discuss benefits issues with employees and their families.

Cost

Since rising health care costs affect both the City and its employees, the City will continue to study new coverage options that help control health care costs. The program is designed to be cost effective, for both the short term and the long term.

The cost of the program is determined on an actuarial basis and does not vary with short term financial considerations. Employee contributions are required to finance the cost of parts of the program.

Communication goals of the benefits program include:

- Educating employees on how to use their benefits
- Educating employees on how to be better consumers of all benefits
- Increasing employee understanding of the value of their benefits

Benefits Eligibility

- Benefits Overview
- Who is Eligible
- Dependent Eligibility
- When Coverage Begins
- Making Changes to Coverage
- Special Enrollment Rules
- Frequently Asked Questions

Who Is Eligible

You are eligible to enroll in the City's benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following your date of hire.

Dependent Eligibility

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your children up to age 26 for medical coverage; your unmarried, eligible children up to age 26 for dental and vision coverage.
    - "Children" are defined as your natural children, stepchildren, legally-adopted children and children for whom you are the court-appointed legal guardian.
- Dependent Grandchildren: Your unmarried grandchild must meet the requirements listed above and must be listed as a dependent on your last IRS Tax Return or your spouse's federal income tax return. Proof of claiming the dependent may be requested from time to time.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested from time to time.

Documentation Required

- To cover a spouse, you must provide a marriage certificate. To cover a child, you must provide a birth certificate or court order in the case of an adopted child(ren) or legal guardianship.

- If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify Human Resources at (512)671-2701.

When Coverage Begins

Initial Enrollment

When you first join the City, you have 31 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins the first of the month following your date of hire. If you do not enroll within 31 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits, such as basic life and accidental death insurance, but you will have to wait until the next annual Open Enrollment to enroll in medical insurance or make changes to coverage. You will be able to utilize the employee assistance program (EAP) upon hire.

Annual Enrollment

Annual Open Enrollment is October 1 through October 31, and coverage takes effect on January 1 of the following year.

Making Changes to Coverage

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment. You are able to make a qualified status change if you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by providing documentation to Human Resources. If you do not enroll online within 31 days, you will have to wait until the next Open Enrollment to make new elections.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

Special Enrollment Rules

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described above, you may enroll yourself and your spouse (with or without the new dependent) in the City health plan following marriage or the adoption, placement for adoption, or birth of a child, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call Human Resources at (512)218-5490.

Plan Choices

- Medical Plan
- Prescription Drug Coverage
- Mail Order Program
- Dental Plan
- Vision Plan
- Life Insurance
- Disability Coverage
- Flexible Spending Accounts

Medical Plan

The City's medical options all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

Network Provider Organizations

The POS plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to an Aetna in-network doctor or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because Aetna network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

Benefit Plan	Automatic	Voluntary	Who Pays	How You Pay
Medical and Prescription Drugs		✓	You and The City	Before tax*
EAP	✓		**The City of Round Rock**	No Cost
Dental		✓	You and The City	Before tax*
Vision		✓	You and The City	Before tax*
new Basic Life and AD&D	✓		**The City of Round Rock**	No cost
Voluntary Life and AD&D		✓	You	After tax
Long Term Disability	✓		**The City of Round Rock**	No cost
Voluntary Short Term Disability		✓	You	After tax
Critical Illness and Accident		✓	You	After tax
Pet Insurance		✓	You	After tax
Flexible Spending Accounts		✓	You	Before tax

Employee Contributions

Aetna Medical POS Rates				
Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
EE Only	$ 800.00	$ 700.00	$ 100.00	$ 50.00
EE + Child(ren)	$ 975.00	$ 700.00	$ 275.00	$ 137.50
EE + Spouse + Child(ren)	$ 1,100.00	$ 700.00	$ 400.00	$ 200.00

Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a **before-tax basis** through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.

The above premiums are in effect January 1, 2014 - December 31, 2014.

Unsure Doctor Referrals are in the Aetna network? All of the providers in the Aetna network change frequently. To find out if your doctor participates in the network, go to www.aetna.com and click on Find a Doctor. Be sure to check out the new Aexcel Network, where office visit copays are less.

Plan Highlights

Plan Provision	In-Network Coverage	new Aexcel Network	Out-of-Network Coverage
new Annual Deductible	$750 Individual $2,250 Family		$2,000 Individual $6,750 Family
new Annual Out-of-Pocket Maximum	$3,000 Individual $9,000 Family		$12,000 Individual $36,000 Family
Preventive Care			
Adult Physical Examinations, including diagnostic tests and immunizations	100%, no deductible		50% after the deductible
Routine OB/GYN Exams, including mammogram and Pap test	100%, no deductible		50% after the deductible
Routine Pediatric Care, including diagnostic tests and immunizations	100%, no deductible		50% after the deductible
Routine Digital Rectal Exam, Prostate-specific Antigen Test and colorectal cancer screening	100%, no deductible		50% after the deductible
Routine Hearing Exams	100%, no deductible		50% after the deductible
Mammograms/Colonoscopies	100%, no deductible		50% after the deductible
Routine Eye Exam	100%, no deductible		50% after the deductible
Outpatient Care	**In-Network**	**Aexcel Network**	**Out-of-Network**
new PCP Office Visit	$25 copay per visit		50% after the deductible
new Specialist Office Visit	$45 copay per visit	$25 copay per visit	50% after the deductible
new Airrosti Office Visit	$25 copay per visit		50% after the deductible
Outpatient Surgery	80% after the deductible		50% after the deductible
X-ray and Lab Tests (non-routine)	80% after the deductible		50% after the deductible
Outpatient Therapy 60 visits per year for the following: speech, physical, occupational, acupuncture and chiropractic)	80% after the deductible		50% after the deductible
new Hearing Aids	80% after deductible/$4,000 Annual Limit		No Coverage
Emergency and Urgent Care			
Emergency Room Care	80% after $200 copay, subject to deductible (Waived if admitted to a hospital within 24 hours)		50% after $200 copay, subject to deductible
Urgent Care	100% after $35 copay		50% after the deductible

A new, improved Aetna Navigator® website is here!

You asked...we listened

You told us how your Aetna Navigator® secure member website could be even more helpful. We heard what you said!

Aetna Navigator now has a new look with more choices. It also has better features that make it faster and easier for you to:

- Find health information
- Get your claims details
- Print member ID cards

www.aetna.com

Can't find what you need? Ask Ann for help!

Ann, Aetna's virtual assistant, is now available to answer more of your Aetna Navigator questions. She will quickly guide you to the information and tools you are looking for.

Ann not only helps you with registration and log-in. She can also help you search for claims, find ID cards, understand health care terms and so much more!

Count on Aetna Navigator. Of course, it still has the same features you've counted on to learn more about how to manage health and health care for you and your family, 24/7.
Just log in to:

- Review coverage details
- Estimate health care costs
- Find doctors, dentists, hospitals and pharmacies

Get Explanation of Benefits statements and much more

new Airrosti

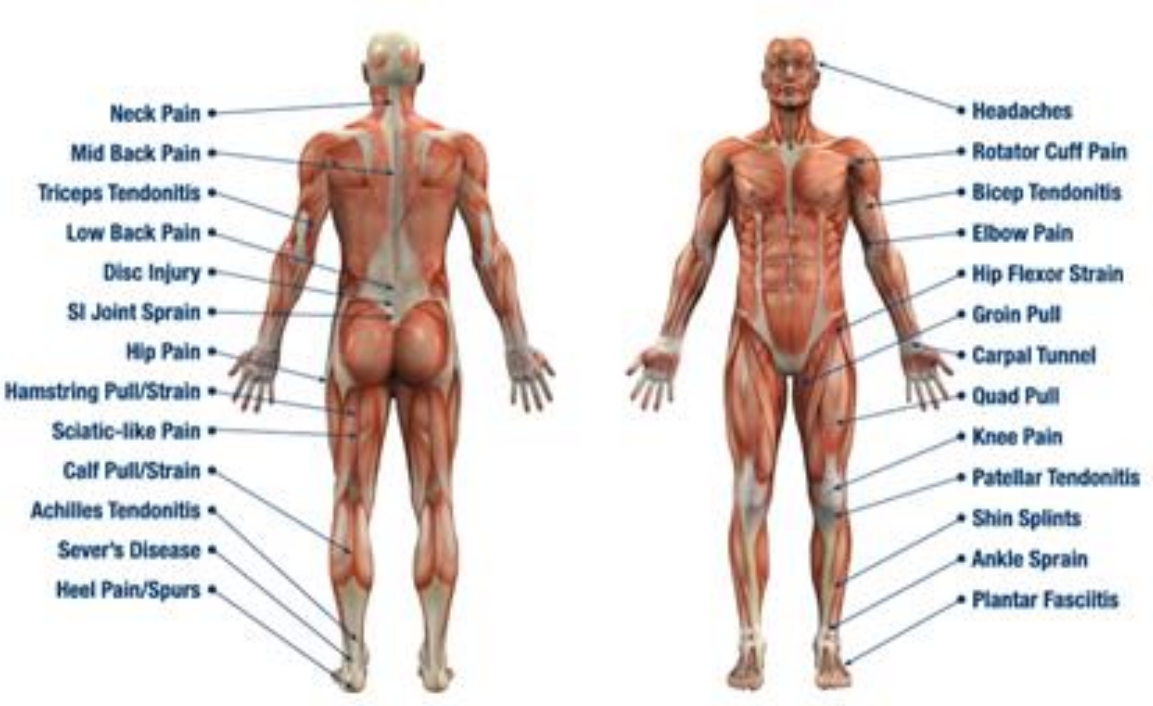
PAIN STOPS HERE

AIRROSTI

An Airrosti Visit for City of Round Rock Employees is $25 Copay!

Airrosti is a healthcare group that employs and trains providers who specialize in delivering high quality, outcome-based musculoskeletal care that prevents unnecessary MRIs, pharmaceuticals, injections and surgeries. Airrosti's quality care approach leads to an accurate diagnosis and treatment. Many patients experience significant improvement in range of motion and a return to normal activity, often within only 3 visits (based on patient-reported outcomes).

Common Injuries/Conditions Resolved By Airrosti Providers



(800) 404-6050 | Airrosti.com

ROUND ROCK, TEXAS
PURPOSE. PASSION. PROSPERITY.

new AETNA Mobile Phone App

The Aetna Mobile application ("app") makes it even easier for Aetna members to get their personal information or complete important tasks on the go. This mobile app is compatible with the Android-powered phones, iPhone®, iPod touch® and iPad™ .

The Aetna Mobile App goes a step beyond the mobile web to offer convenience and personalized features.

ANDROID APP ON Google play

Available on the iPhone App Store

Use the Aetna Mobile app to:

Find a Doctor, Dentist or Facility

Search for a doctor or facility in Aetna's network by location, name or specialty. This makes it quick and easy to get a phone number or find a doctor near you.

Urgent Care Finder

Find urgent care centers and walk-in clinics without even logging in at home or at work, while traveling for vacation or business. A map provides turn-by-turn directions.

Look Up Claims

You can see the status of your most recent medical, dental and pharmacy claims. No waiting until you can get to your computer. You can also search for a claim by member name or date.

Check Coverage and Benefits

View your plan's deductible and coinsurance information, including limits, amounts applied to date and balances. You can also view Flexible Spending account balances.

View Your Member ID Information

View your medical and dental ID card information. This is handy if you don't have your card with you at the doctor's office.

Check Drug Prices

Check and compare drug prices – based on your plan* – before you fill a prescription. See the Aetna Rx Home Delivery® and retail pharmacy costs based on your coverage and benefits. You must be registered on Aetna Navigator to use the apps or mobile web.

Please note: If you log in to the mobile app and can only see the Find a Doctor feature, it may be time to confirm or update your profile information on the secure member website. (If you are not prompted to confirm or update your profile, please contact Member Services for further assistance.) Once your profile is validated, log in to the app again. You will then be able to access your personal information, such as claims and member ID cards.

You must always sign in with your User Name and Password to access the features in this app. Without that information, no one can reach your personal data. It is safe.

Download app at:
https://play.google.com/store/apps/details?id=com.usablenet.android.aetna&feature=search_result

Prescription Drug Coverage

If you enroll in the City's medical plan, you will automatically receive prescription drug coverage. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order pharmacy program.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

new Retail (30-day Supply)	Amount You Pay
Generic:	Free
Preferred Brand:	$30
Non-Preferred Brand:	$50

Mail Order Program

For people who take medicine regularly for chronic conditions, prescription drug costs can be expensive. Mail order service can help. Aetna Rx Home Delivery® fills prescriptions for millions of members who take medications for arthritis, asthma, diabetes, high cholesterol, high blood pressure and other chronic conditions.

Advantages:

- Convenient, consistent care – Instead of monthly trips to the pharmacy, you can get medications shipped directly to your home.
- Great supplies, lower copayments. Instead of a 30-day supply, you get a 90-day supply, with your doctor's approval. And, depending on your plan, you may pay less for that larger amount than for three smaller fills at a retail pharmacy.
- *Generic mail order prescriptions are FREE!*

ORDERING REFILLS IS EASY – Choose one of these ways

1. **Online:** You go online to order refills, track the status of an order, and more. Just visit **www.aetna.com** and log into Aetna Navigator. Or go directly to **www.aetnanavigator.com.**

2. **By Phone:** Call Rx Member Services toll free at (888)RX- AETNA (1-888-792-3862). Have your member ID number, your prescription number, and your credit card number ready.

3. **By Mail:** Send in the reorder form that you received with your last order. Mail it back with your payment. The reorder form will also tell you when you can place your next refill order.

Mail Order (90-day Supply)	Amount You Pay
Generic:	Free
Preferred Brand:	$50
Non-Preferred Brand:	$90

new Prescription Drugs Phone App

Stop paying too much for your prescriptions!

Compare prescription prices at over 70,000 pharmacies, and discover free coupons and savings tips.

Find the lowest price on prescriptions right from your phone

The free, easy-to-use mobile application features:

- Instant access to the lowest prices for prescription drugs at more than 75,000 pharmacies
- Coupons and savings tips that can cut your prescription costs by 50% or more
- Refill reminders with the latest prices to help you take advantage of price changes

Download for Android

Available on the App Store

To download go to:

https://play.google.com/store/apps/details?id=com.goodrx#?t=W251bGwsMSwyLDEsImNvbS5nb29kcngiX0..

Or, just go to m.goodrx.com from any mobile phone

Consumer Reports Picks GoodRx's Mobile App

Consumer Reports tested 4 mobile prescription drug-finding apps. Their verdict?

Use GoodRx's. Read the full report.

Dental Plan

The City's Dental Plan is administered through Aetna and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings and orthodontia for children.

Dental PPO Plan

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of Aetna's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims.

For a list of Aetna's preferred dentists, go to **www.aetna.com**.

You will receive a dental card from Aetna but you do not need to use the dental ID card to receive dental services. When you visit the dentist, give the provider your Social Security number and the City's name. Your dentist's office can verify your eligibility for benefits by calling Aetna at (877)238-6200.

Dental Plan Highlights

Plan Feature	PPO PLAN
Annual Deductible ■ Individual ■ Family	 $50 $150
Annual Benefit Maximum	$1,500
Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers)	100% (no deductible)
Basic Services (X-rays, fillings, sealants, denture repairs)	80% after deductible
Major Services (Crowns, inlays, onlays, bridges, dentures)	50% after deductible
Orthodontia	50% after $50 deductible, up to a lifetime maximum of $1,500 (children to age 20 only)

Employee Dental Contributions

Below are the premiums that are in effect January 1, 2014 - December 31, 2014.

Aetna Dental Plan Rates				
Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
EE Only	$22.00	$12.00	$10.00	$5.00
EE/Spouse	$36.24	$12.00	$24.24	$12.12
EE/Child(ren)	$34.26	$12.00	$22.26	$11.13
EE/Family	$53.52	$12.00	$41.52	$20.76

Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a **before-tax basis** through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.

Vision Plan

The City's basic Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Aetna.

Vision Coverage

The PPO plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to an Aetna in-network doctor or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because Aetna network providers discount their fees. And, with in-network providers, you generally do not have to file claims. If you choose to receive care from an out-of-network provider, the plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses. To find a vision network provider, go to www.aetna.com.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear. So be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Comprehensive Exam **Lenses** (including contact lenses)* **Frames**	1 Every Rolling 12 Months 1 Every Rolling 12 Months 1 Every Rolling 12 Months	
Routine/Comprehensive Eye Exam Benefit	**NOTE: Medical Plan covers one free eye exam per year.** $10 Copay	Up to $ 25 Reimbursement
Exam Options: **Standard Contact Lens** Fit & Follow Up **Premium Contact Lens** Fit & Follow Up	Member pays discounted fee Member pays discounted fee	Not Covered Not Covered
Frames (Any available frame at provider location)	$130 Plan Allowance. Member pays 80% of balance over $130	Up to $ 65 Reimbursement
Standard Plastic Lenses: **Single Vision** **Bifocal** **Trifocal** **Lenticular** **Standard Progressive Lens** **Premium Progressive Lens**	 $10 Copay $10 Copay $10 Copay $10 Copay Member Pays $ 85 $ 120 Plan Allowance. Member Pays $ 85 (Member pays 80% over $120 Plan Allowance	 Up to $15 Reimbursement Up to $ 30 Reimbursement Up to $ 60 Reimbursement Up to $ 60 Reimbursement Up to $ 30 Reimbursement Up to $ 30 Reimbursement

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Lens Options:		
UV Treatment	Member Pays $15	Not Covered
Tint (solid and gradient)	Member Pays $15	Not Covered
Standard Plastic Scratch Coating	Member Pays $15	Up to $ 15 Reimbursement
Standard Polycarbonate – Adults	Member Pays $40	Not Covered
Standard Polycarbonate –Kids >13	Member Pays $40	Up to $ 15 Reimbursement
Standard Anti-Reflective Coating	Member Pays $45	Not Covered
Polarized	Member Pays 80% of Retail	Not Covered
Contact Lenses	Contact Lenses Reimbursement Includes Materials Only	
Conventional	Member pays 85% over $130	Up to $ 90 Reimbursement
Disposable	Member pays 100% over $130	Up to $ 90 Reimbursement
Medically Necessary	$0 Copay	$ 200 Reimbursement
Laser Vision Correction Lasik or PRK from US Laser Network**	15% off retail price or 5% off promotional price	Not Covered
Second Pair Discount	Member can receive up to 40% off additional pairs of eyeglasses. Additional discounts are available on contact lens purchases. Use of this program is unlimited.	Not Covered

Employee Contributions

Below are the premiums that are in effect January 1, 2014 - December 31, 2014

Aetna Vision Plan Rates				
TIER	2014 RATE	CITY PAYS	MONTHLY DEDUCTION	PER PAY PERIOD
EE Only	$ 5.77	$ 5.77	$ 0.00	$ 0.00
EE/Spouse	$ 10.97	$ 6.00	$ 4.97	$ 2.49
EE/Child(ren)	$ 11.55	$ 6.00	$ 5.55	$ 2.78
EE/Family	$ 16.98	$ 6.00	$ 10.98	$ 5.49

*Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a **before-tax basis** through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.*

new Life Insurance

Basic Life Insurance

The City of Round Rock automatically provides Basic Life and Accidental Death and Dismemberment Insurance for all eligible employees at no cost. Basic Life Insurance and Accidental Death and Dismemberment equal to your annual base earnings up to a maximum of $100,000. The benefit is paid to your beneficiaries in the event of your death.

Annual base earnings include your base salary and any overtime or bonuses. Interest is not included.

Supplemental Death Benefit

The City still provides a Supplemental Death Benefit in the retirement program. If you die while employed by the City, Texas Municipal Retirement System (TMRS) will pay your beneficiary or estate a benefit approximately equal to your current annual salary.

You are automatically enrolled, with no cost to you, for the Supplemental Death Benefit when you enroll with TMRS. The benefit is paid to your beneficiaries or estate in the event of your death.

Basic Life Insurance Coverage IRS Rules

If your Basic Life Insurance coverage is more than $50,000, your income taxes may be affected. IRS regulations require that the value of life insurance benefits over $50,000 be reported as "imputed income," which is non-cash income you receive from an employer-provided benefit. The value of any coverage that exceeds $50,000 will be reported to the IRS as imputed income and TMRS will provide the beneficiary with a 1099-R form.

Optional Life Insurance

In addition, you may also purchase Optional Life Insurance for yourself, your spouse and your dependent. However, you may only elect coverage for your dependents if you enroll for Optional Life coverage for yourself. You pay for the cost of Optional Life Insurance on an after-tax basis through payroll deductions. Optional Life and AD&D insurance will be taken from your paycheck on a post-tax basis.

Beneficiary Designation

You must designate a beneficiary for your Supplemental Death benefit when you enroll with TMRS. Your beneficiary is the person(s) who will receive the benefits from your Supplemental Life Benefit in the event of your death. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your life insurance benefits will go to a probate court.

Additionally, you must designate a beneficiary for your city paid basic life insurance, wages and any reimbursements owed to you by the City of Round Rock at the time of your death. You may do so by completing the Beneficiary Designation Form available on the Benefits Portal or at the Human Resources Office.

Disability Coverage

The City offers you a disability plan that works to keep all or part of your paycheck coming if you cannot work because of illness, injury or pregnancy.

Short-Term Disability

Short-term disability (STD) benefit is available to all eligible employees. If you remain totally disabled and unable to work for more than 8 days, you may be eligible for Short-Term Disability (STD) benefits. This coverage automatically provides you STD benefits that replace up to 60% of your weekly salary for a length of time that you choose (either 15 weeks or 25 weeks). This benefit is paid for by the employee.

Long-Term Disability

If you remain totally disabled and unable to work for more than 180 days, you may be eligible for Long-Term Disability (LTD) benefits. The City automatically provides you LTD benefits that replace up to 60% of your base pay, up to a maximum of $5,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job at the City, and
- You must have lost 20% or more of your pre-disability income due to your illness or injury.

Flexible Spending Accounts

The City allows you to contribute to one or both flexible spending accounts, which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by Aetna.

How the FSAs Work

The City offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year. Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule.

Health Care FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

For a complete list of eligible expenses, visit **www.aetna.com**.

An Enrollment Form *must be* completed for the next January 1 effective date.

NOTE: ***YOU MUST COMPLETE A NEW FSA REIMBURSEMENT FORM AND RE-ENROLL EACH OPEN ENROLLMENT TO CONTINUE YOUR FLEXIBLE SPENDING ACCOUNT.***

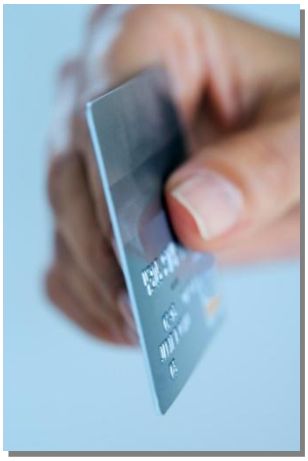
Annual Contribution Amount

You can contribute $250 up to a maximum of $2,500 per year to the Health Care FSA.

A Note Regarding Over-the-Counter Medications

You must have a doctor's prescription to use the Health Care FSA to reimburse yourself for certain over-the-counter medications. Examples of medications that require you to submit a doctor's prescription include:

- Acid controllers, digestive aids and stomach remedies
- Allergy and sinus medicines
- Anti-itch and insect bite remedies
- Cold sore remedies
- Cold, cough and flu drugs
- Pain relief medications
- Respiratory treatments
- Sleep aids and sedatives



How the FSA Debit Card Works

If you enroll in the Health Care FSA, you will receive one debit card in the mail. To request additional debit cards for your family members or if you lose your card, please contact Aetna at 1-866-229-1512.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. If you use your debit card at a health care provider's office or at a vendor that has the software in place to track eligible FSA expenses, you will not be required to submit a receipt. For a list of vendors that have this software, go to **www.aetna.com. However, for most debit card transactions, you will need to submit your receipts as substantiation of your expense, so it's important to keep them.**

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

Savings with a Health Care FSA

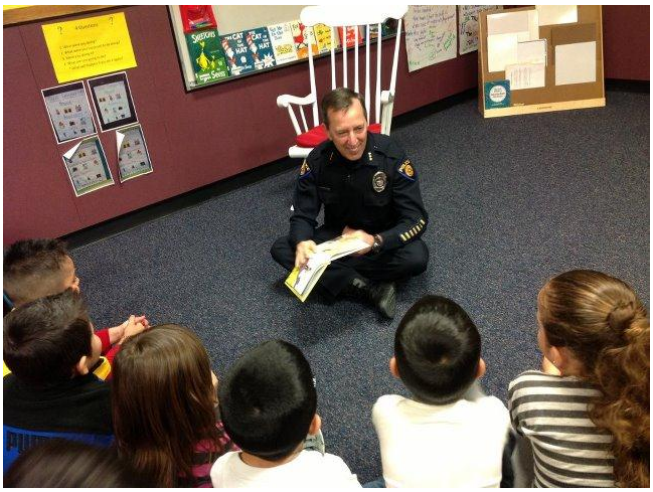
Sample Healthcare Expenses	Your Cost Without a FSA	Your Cost With a FSA	Your Estimated Out-of-Pocket Savings*
Doctor Copay	$35.00	$24.50	$10.50
Specialist Copay	$45.00	$31.50	$13.50
Monthly Diabetic Supplies	$100.00	$70.00	$30.00
Monthly Orthodontic Payment	$125.00	$87.50	$37.50
Eyeglasses	$300.00	$210.00	$90.00
Laser Eye Surgery	$2,500.00	$1,750.00	$750.00

*based on the 10% tax bracket

Health Care Flexible Spending Account Worksheet

Use the following worksheet to estimate your out of pocket expenses for the year (January 1 to December 31, 2014). Some common Flexible Spending Health Care expenses are listed below or go to **www.irs.gov**.

	Employee	+ Dependents	= Total
Prescription Copays	You save money by using generic drugs. Review your maintenance and prescribed over-the-counter prescriptions to see if you are choosing the most economical option.		
Medications (including prescribed over-the-counter prescriptions)	$_____	+ $_____	= $_____
Doctor Visit Copays	$_____	+ $_____	= $_____
Scheduled	$_____	+ $_____	= $_____
Non-Scheduled	$_____	+ $_____	= $_____
Medical Procedures	Some examples of eligible expenses include laser eye surgery, outpatient surgery, hospital copays, coinsurance, hospital stays and lab work.		
Procedures	$_____	+ $_____	= $_____
Dental Care Costs	Examples include orthodontia, root canals, fillings, night guards, splints, etc.		
Routine Dental Expenses	$_____	+ $_____	= $_____
Specialized Procedures	$_____	+ $_____	= $_____
Orthodontia	$_____	+ $_____	= $_____
Vision Care Costs	$_____	+ $_____	= $_____
Estimated annual total of out-of-pocket health care expenses:			$
Divide total by 24 payroll deductions. (New employees divide by the remaining number of calendar year pay periods, after your hire date).			÷ 24
Estimated contribution per pay period. (This is the amount you enter into the Health Care block during online open enrollment).			= $_____
Maximum deduction is $104 per pay period (cannot exceed $2,496)			



Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be:
  - Employed, or
  - A full-time student at least five months during the plan year, or
  - Mentally or physically disabled and unable to provide care for himself or herself

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care of:

- Your children under age 13 whom you claim as a dependent for tax purposes
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

For a complete list of eligible expenses, visit **www.irs.gov.**

Example

Sample Dependent Care Expenses	Your Cost Without A FSA	Your Cost With A FSA	Your Estimated Out-of-Pocket Savings*
Daycare for Child Under Age 13	$5,000	$3,500	$1,500
Before/After School Care	$4,000	$2,800	$1,200
Summer Camp	$2,400	$1,680	$720
Disabled/Elder Adult Daycare	$5,000	$3,500	$1,500

*Based on 15% tax bracket

Annual Contribution Amount

You can contribute $250 to $5,000 per year to the Dependent Care FSA.

Important FSA Considerations

- Any money left in your FSAs at the end of the plan year may not be rolled over to pay for future expenses in another plan year. Any unused funds will be forfeited, per IRS rules.
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year—even if you have not yet contributed that much to your account.)
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.

Dependent Care Flexible Spending Account Worksheet

Use the following worksheet to estimate your out of pocket expenses for the year (January 1 to December 31, 2014). Some common Flexible Spending Dependent Care expenses are listed below or go to **www.irs.gov**.

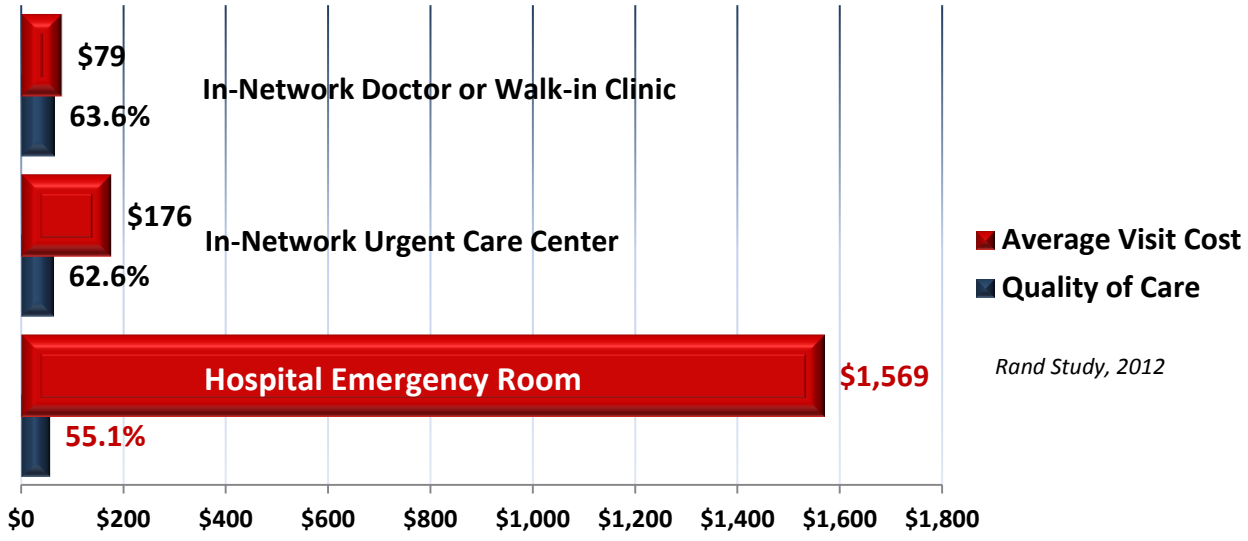
Activity/Age	Monthly Costs	Number of Months	Number of Children	Total Costs
Day Care – 6 years and under, still not in first grade	$_____	X _____ Months	X _____ Children	= $_____
Before School Childcare – children up to age 13	$_____	X _____ Months	X _____ Children	= $_____
After School Childcare – children up to age 13	$_____	X _____ Months	X _____ Children	= $_____
Summer are or Day Camp – children up to age 13	$_____	X _____ Months	X _____ Children	= $_____
			Estimated annual total of out-of-pocket dependent care expenses:	$_____
Divide total by 24 payroll deductions. (New employees divide by the remaining number of calendar year pay periods, after your hire date).				÷ 24
(This is the amount you enter into the Dependent Care block during online open enrollment).			**Estimated contribution per pay period.**	= $_____
Maximum deduction is $208 per pay period (cannot exceed $4,992)				

It's important to keep copies of all your receipts—(for both health care and dependent care) even if you are not required to submit them as proof of your expense. That way, if the IRS asks for substantiation of your expenses, you will have the receipts.

Other Benefits

- Medical Tips
- Retirement
- Employee Assistance Plan (EAP)
- Education Assistance
- Clay Madsen Recreation Center
- City Pools
- Library Card

Should I go to the Doctor, Walk-In Clinic, Urgent Care or Emergency Room?



Accidents and illnesses can happen at any time. And knowing where to seek care is not always easy. Research shows that Emergency Room (ER) visits have increased by more than 30 percent in the past decade. ***Going to the ER isn't always the best choice—for your care or your wallet.*** One of the best ways to reduce healthcare costs is to limit trips to the emergency room to true emergencies - life-threatening medical problems - build a relationship with a primary care physician for routine care. It's a healthy way to keep healthcare affordable.

In a true emergency, you shouldn't hesitate to go to the ER. BUT...if your condition is not an emergency, check with your doctor first or call an urgent care facility. **Knowing your healthcare choices can help save time and money. Use this chart as a guide:**

Out of Pocket Cost	Where to go	When to go	Examples	Average Cost
Lowest	In-Network Doctor or Clinic	For routine care during office hours	Health Exams, Cold, Flu, sore throats, minor injuries, aches and pains	$79
Moderate	In-Network Urgent Care Clinic	For non-emergency needs when your doctor's office is closed or if you can't use an in-network clinic and you need immediate medical attention	Simple bone breaks, cuts, burns, ear infections, sprains and minor injuries	$176
Highest	In-Network Hospital Emergency Room	Use the ER if you have serious symptoms or a life-threatening emergency	Severe bleeding, chest pains, broken bones and poisoning	$1,569

Texas Legal Plan

Membership grants a member access to a host of legal benefits that are available and renew each year. You will have the opportunity to solve your legal matters at a reduced rate, without reducing the level of service.

Retirement

The City values you as an employee. As part of your compensation, the City provides retirement benefits. Over the years, the City has made a significant investment in providing retirement benefits to employees, so it is important that you understand how your retirement benefits work.

Several programs are available to help you prepare for your retirement. These programs include mandatory participation in retirement systems and City contributions to Social Security on your behalf.

For more information about your defined benefit retirement plan, contact your retirement system.

Texas Municipal Retirement System (TMRS)

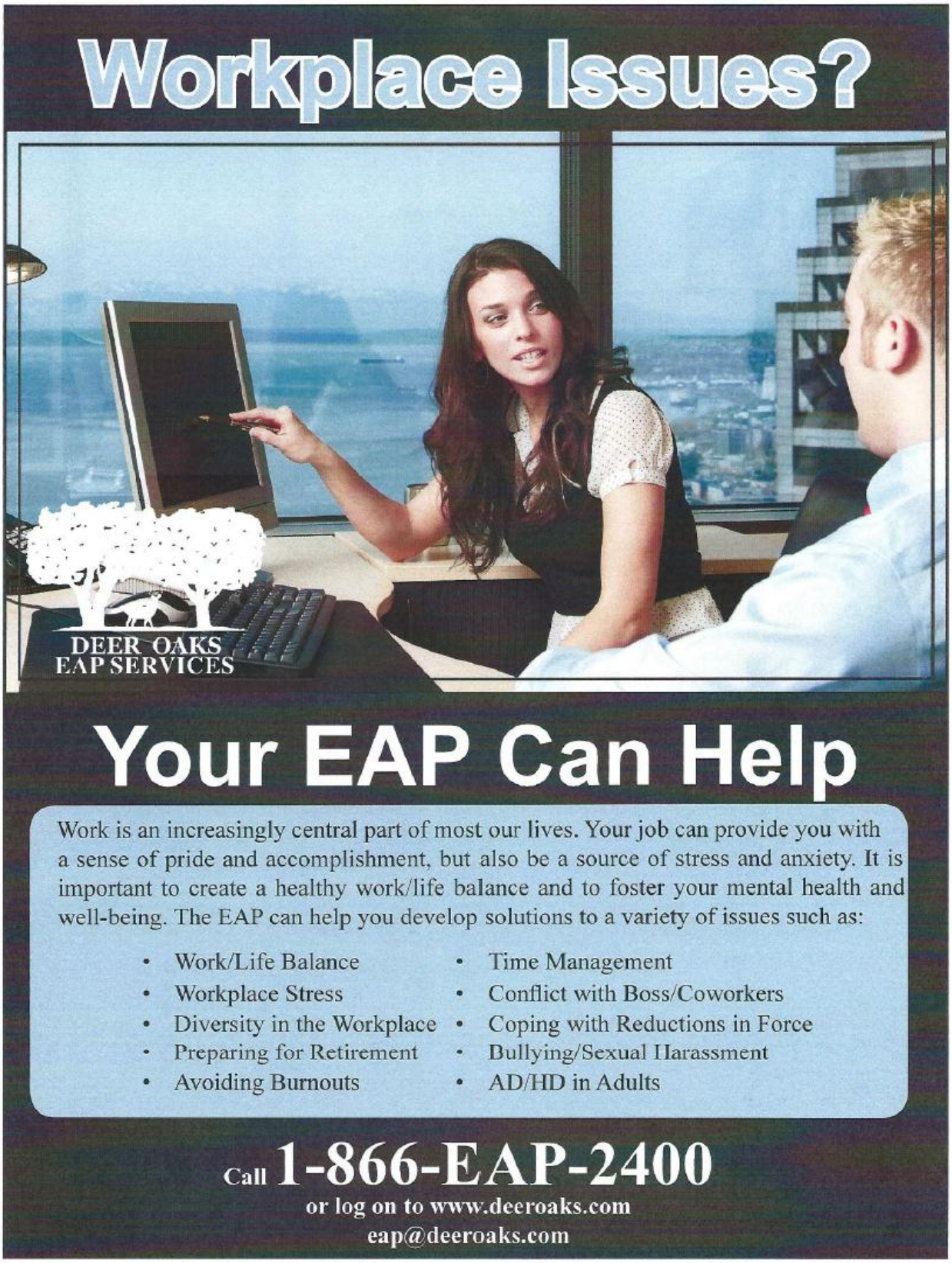
The City's retirement program is with TMRS. Full-time employees contribute a mandatory 7% of their salary. The City contributes a ratio of 2:1 to the employee's fund after the employee has become vested (five years) AND retires (after 20 years of service OR at age 60 with five years of service). The retirement fund earns interest. The City also participates in Social Security. A Supplemental Death Benefit is also provided by TMRS at one times your annual salary.

457 Plans Deferred Compensation

Nationwide is an investment company that offers additional options for retirement.

- 457 Deferred Compensation Plan – this plan is similar to a 401(k). You may choose the type of investment options and investment amount per pay period (IRS annual maximum for 2013 is $17,500.). This amount is payroll deducted pre-tax. You can enroll, change, or cancel at any time.
- This plan is fully funded by you—the City does not contribute to this plan. Online enrollment is also available at **www.nrsforu.com**
- Roth 457 – a flexible retirement savings option that may offer some unique tax advantages in addition to the benefits already available through your deferred compensation plan.
- This plan is fully funded by you—the City does not contribute to this plan. Online enrollment is also available at www.nrsforu.com

Employee Assistance Program



Education Assistance

This benefit is to provide financial assistance to employees who are seeking education for career and/or job related development and who are taking for-credit courses through an academic institution. Regular full-time employees with six or more months of service may be eligible for education assistance. The City provides up to $2,000 in education assistance per fiscal year to eligible employees. These funds are allocated on a first-come, first-served basis. Classes must be offered by an accredited school or university and must have the opportunity to be taken for a grade.

Clay Madsen Recreation Center

The City provides all employees the opportunity to choose either a free individual Clay Madsen Recreation Center (CMRC) membership or a discounted family membership. Only immediate family members are eligible to be covered under the discounted family membership. The CMRC is a fully equipped recreation facility with an indoor pool.

Employee & Family Pool Pass (Seasonal Benefit)

The City provides all employees an Employee & Family Pool pass for recreation swimming. This pass provides free admittance to all City pools for employees and their immediate family members.

Round Rock Public Library Card

All City employees receive a free Round Rock Public Library Card regardless of City residence. Employees interested in obtaining a library card should complete an application at the Library.

Frequently Asked Questions

Eligibility Questions

Q. If I am not sure how to access my benefits or who to call, where should I begin?

A: You may reference this guide for all online and telephone contact information for your insurance carriers. If you need assistance with any benefits offered by the City, call the Human Resources Department at (512)218-5490.

Q. How do I enroll my newborn in my medical plan?

A. You will need to call the Human Resources Department at (512)218-5490 *within 31 days of your child's birth* to schedule an appointment with the Benefits Specialist. You must provide a certified birth certificate, the complimentary birth certificate, or a verification of birth facts issued by the hospital and complete a Benefits Enrollment Form.

Q. Can I include my parents on my insurance plan?

A. No. Parents cannot be enrolled in benefits offered by the City.

Q: Can I include my grandparents on my insurance plan?

A: No. A Grandparent cannot be enrolled.

Q. My child is graduating from college next week, and will turn 21 next month; do I have to drop him/her from my insurance?

A. No. Your dependents may continue coverage until age 26, as long as they meet the eligibility requirements.

Q. I am resigning my position from the City, how can I continue my coverage?

A. COBRA is offered to you and your covered dependents when coverage is ended. You will receive a COBRA information packet within 3 weeks of your separation.

Benefits Questions

Q. How do I begin the process for Long Term Disability?

A. Please call the Human Resources Department at (512) 218-5490 and speak with the Benefits Division.

Q. When can I expect to receive my ID cards?

A. You should receive your ID cards within four to six weeks of enrolling or making changes to your benefits.

Q. If I need to see a doctor or have a prescription filled prior to receiving my ID card, what should I do?

A. You can print temporary ID cards from **www.aetna.com**. You can present these cards to your doctor to verify benefits.

Q. Can I make changes to my benefits during the year?

A. Yes, within 31 days of a qualifying life event, such as adding a newborn, marriage/divorce, loss of coverage, or receiving coverage through another company.

Q. If I am called for Military Leave, what steps should I take concerning my benefits?

A. Please call the Human Resources Department at (512) 218-5490 and speak with the Benefits Division.

Q. I will be out on leave (without pay). What should I do to make sure that my benefits continue?

A. Please call the Human Resources Department at (512) 218-5490 to make arrangements to pay your benefit premiums.

Required Health Coverage Notices For Your Files

This brochure contains legal notices that are required to be distributed to participants in group health plans sponsored by the City of Round Rock.

The notices included in this brochure are:

- **Notice of Privacy Practices** that explains how the City of Round Rock group health plans protect your personal medical information.
- **Medicare Part D Notice** that provides information about how your current prescription drug coverage under the City of Round Rock healthcare plans is affected—and your options for coverage—when you become eligible for Medicare.
- **COBRA Rights Notice** that explains when you and your family may be able to temporarily continue coverage under the City of Round Rock health plans if coverage would otherwise end for you.
- **Newborn & Mothers Health Protection Notice** that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- **Women's Health and Cancer Rights Act** that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- **Notice of Special Enrollment Rights**
- **New Health Insurance Marketplace Coverage Options and Your Health Coverage** that explains key parts of the health care law taking effect in 2014.

Group Health Plan Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Duties

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this notice but reserve the right to change the terms of the notice and to make the new notice provisions effective for all protected health information we maintain. If we change the terms of the notice, we will provide you with a copy of the revised notice by letter and posting. This notice will remain in effect until replaced or amended. Detailed large claim health information received from healthcare vendors will only be viewed by individuals in the following positions: Benefits manager, Human Resources Director, Benefits Specialist, and the City Attorney assigned to Human Resources. These employees have a legitimate business need to view this information in order to consider alternate health insurance funding options for the city.

Your Protected Information

In order to conduct operations, our designated agents or we, collect, create and/or use different types of information. This may include information about you such as your name, address, age, health status, medical or psychological conditions, and information about dependents. Some of this information may qualify as *protected health information*. Our use or disclosure of *protected health information* may be restricted or limited by law. *Protected health information* means individually identifiable health information that is transmitted by electronic media, maintained in electronic or computer format, or transmitted or maintained in any other form or medium. *Protected health information* does not include certain educational or employment records.

Permitted Uses and Disclosures of Your Protected Information

For Payment – Our designated agents or we may use and disclose information about you in managing your healthcare. This may include such functions as premium payment activities, reimbursing healthcare providers for services, determining eligibility or coverage of an individual, performing coordination of benefits, adjudicating claims, healthcare data processing including claims management, collection activities, obtaining payments under a reinsurance contract, medical necessity reviews, and/or utilization review activities.

For Healthcare Operations – Our designated agents or we may use and disclose information about you for healthcare operations. This may include information about you needed to review the quality of care and services you receive, to provide case management or care coordination services, provide treatment alternatives or other health-related benefits and services, and/or to perform audits, ratings, and forecasts (as limited by HIPAA standards).

For Treatment – Our designated agents or we may use and disclose information about you for treatment purposes. This may include information about you needed for the provision, coordination, or management of healthcare and related services.

As Permitted or Required by Law – **Information about you may be used or disclosed to regulatory agencies, for administrative or judicial proceedings, for health oversight activities, to law enforcement officials when required to comply with a court order or subpoena, and/or as authorized by and to the extent necessary to comply with workers' compensation laws.**

Public Health Activities – Information about you may be used or disclosed to a public health authority for the purposes of preventing or controlling disease, injury or disability, reporting child abuse or neglect, and/or to assist the Food and Drug Administration in tracking products and defects/problems as well as enabling product recalls and conducting post marketing activities. Information about you may also be used or disclosed if we reasonably believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Abuse, Neglect or Domestic Violence – To the extent required or authorized by law, or with your consent, protected information about you may be disclosed to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
In the Event of Death – In the event of your death, our designated agents or we may disclose your protected information to coroners, medical examiners and/or funeral directors as necessary to carry out their duties.

Organ Transplant – Our agents or we may use or disclose your protected information to organ procurement organizations or related entities for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research Purposes -- Our agents or we may use or disclose your protected information for research provided we first obtain an authorization or waiver from you and representations from the researcher limiting the uses and protecting the privacy of your information.

Correctional Institutions – Our agents or we may use or disclose your protected information to a correctional/custodial institution or appropriate law enforcement official if you are an inmate and the disclosure is necessary for your healthcare and the health and safety of you, other inmates, officers or institution employees.

Business Associates – Where it is necessary to help carry out our healthcare function, we may disclose your information to a business associate and/or allow the business associate to create or receive protected health information on our behalf. In most situations, we must first obtain satisfactory written assurances that the business associate will appropriately safeguard the information. No such assurances are required, however, where disclosure is made to your healthcare provider for treatment purposes.

Minimum Disclosure Required – When using, disclosing or requesting your information, we are normally required to make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. This limitation does not apply in situations involving disclosures to you or made pursuant to your authorization, to a healthcare provider for treatment, to the Secretary of Health and Human Services for HIPAA compliance and enforcement purposes, or as otherwise required by law.

Authorization – Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke, in writing, any such authorization unless we have taken action in reliance on your authorization or it was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy.

To Employer –**Our designated agents or we may disclose your information to your employer to conduct an evaluation relating to medical surveillance of the workplace, to evaluate whether you have a work-related illness, to record such illness or injury as required by law. Prior to disclosing this information to your employer, we must give you written notice at the time the healthcare is provided or, if the healthcare is provided at the work site, prominently post the notice at that location.**

Informational Contact – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Plan Sponsor – We may disclose protected information to the Plan Sponsor only in the form of de-identified summary information and to record enrollments and dis-enrollments

Your Rights

Under the regulations you will have the right to:

- Send us a written request to see or get a copy of the protected health information that we have about you.
- Request an amendment to your personal information that you believe is incomplete or inaccurate. The request must be in writing and provide a reason to support the proposed amendment.
- Request in writing additional restrictions on uses or disclosures of your protected health information to carry out treatment, payment, or healthcare operations. However, we are not required to agree to these requests.
- Receive an accounting of our disclosures of your protected health information in writing, except when those disclosures are made for treatment, payment or healthcare operations, or when the law otherwise restricts the accounting.
- Receive a paper copy of this notice upon request.
- You cannot be forced to waive your rights established by the privacy regulations.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address. **(Applies to Healthcare Provider**)
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address, if communication to your home could endanger you. **(Applies to Health Plan)**

Complaints

If you believe your HIPAA privacy rights have been violated, you have the right to file a complaint with either the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201, or Jay Light, City of Round Rock, Benefits Manager, 231 E. Main Street, Round Rock, Texas, 78664, (512) 341-3143. The complaint must be in writing, either on paper or electronically, name the person that is the subject of the complaint and describe the acts or omissions believed to be in violation of your rights. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing a complaint.

Further Information

If you need further information, please contact our HIPAA Contact Office, Human Resources, 231 East Main Street, Round Rock, Texas, 78664, Phone: (512) 218-5490.

From this day forward “Our Duties” of the Notice of Individual Privacy Rights will include the following:

Detailed large claim health information received from healthcare vendors will only be viewed by individuals in the following positions: Benefits manager, Human Resources Director, Benefits Specialist, and the City Attorney assigned to Human Resources. These employees have a legitimate business need to view this information in order to consider alternate health insurance funding options for the city.

Medicare Part D Notice

Important Notice from City of Round Rock about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Round Rock and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Round Rock has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

- **If you are an active employee** and you decide to enroll in a Medicare prescription drug plan and drop your City of Round Rock Health Plan prescription drug coverage, you and your dependents may not be able to re-enroll in the City of Round Rock Health Plan coverage until the next annual enrollment period.
- **If you are a retiree** and you decide to enroll in a Medicare prescription drug plan and drop your City of Round Rock Health Plan prescription drug coverage, you and your dependents will not be able to re-enroll in the City of Round Rock Health Plan coverage in the future.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Round Rock and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Round Rock changes. You also may request a copy of this notice at any time.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Round Rock changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Name of Entity/Sender:	City of Round Rock
Contact–Position/Office:	Jay Light, Benefits Manager
Address:	231 East Main Street, Suite 100 Round Rock, TX 78664
Phone Number:	(512) 341-3143

Keep this notice.

If you enroll in a Medicare-approved plan that offers prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

COBRA Rights Notice

What is Continuation Coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the City of Round Rock Human Resources Department of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the City of Round Rock Human Resources Department, 231 E. Main Street, Round Rock, TX 78664 or call (512)218-5490 to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the date indicated on your COBRA Notice for that coverage period. You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the City of Round Rock, 231 E. Main Street, Round Rock, TX 78664.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact the City of Round Rock Human Resources Department at 231 E. Main Street, Suite 100 Round Rock, TX 78664 or call (512)218-5490.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at **www.dol.gov/ebsa** or call their toll-free number at 1-866-444-3272 For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov**.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

Other Notices

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact The City of Round Rock Human Resources Department.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Human Resources Department
City of Round Rock
231 E. Main Street
Round Rock, TX 78664